

RADICAL TREATMENT FOR CURVATURE OF THE PENIS.¹

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By curvature of the penis is commonly meant a bending downward of the organ when in a state of erection, and such is the significance of the term in this connection. Anything which robs the corpus spongiosum of its natural elasticity, so that it fails to lengthen, as do the corpora cavernosa during erection, will cause curvature, and the amount of the curvature will correspond to the loss in the elasticity. Acute inflammations involving the periurethral tissues temporarily produce this deformity, and any inflammation or traumatism which leaves a permanent cicatrix in the corpus spongiosum will serve to render it lasting. The danger of causing chronic curvature is a chief objection to internal urethrotomy. Most curvatures are not sufficient to act as a bar to sexual intercourse, and, as many of them slowly tend to improve or to become tolerable, nothing in the way of radical treatment is usually demanded or advisable. In the case I have to report, however, the curvature was so extreme as to act as a complete bar to the accomplishment of sexual intercourse, and, as the subject was a young man of twenty and an only son, it was most natural for his parents to urge that something radical should be done. The history of the case is as follows:

¹ Read at the May, 1900, meeting of the American Association of Genito-Urinary Surgeons, held at Washington, D. C.

When twelve years of age he contracted gonorrhœa from his nurse. The inflammation ran a very severe course. Two years later, stricture of the anterior urethra having formed, internal urethrotomy was performed by a prominent specialist. Much inflammation followed the operation, together with the permanent development of the marked degree of curvature just mentioned. On examination, the entire anterior urethra, when felt from the outside, appeared as a hard, unyielding mass.

In order to test the degree of curvature, the patient was made to induce an erection. The thickened urethra then stood out prominently, much like the cord to a bow. In its middle penile portion, however, there was an especially thick node, which I took to mark the site of the chief stricture and the spot where the deepest cutting had been done in connection with the previous internal urethrotomy. It also appeared as if some of the shortening were due to an arrest in the development of the urethra and the corpus spongiosum, caused, perhaps, by the effects of inflammation and urethrotomy on a young growing subject.

The parents were much discouraged. They had taken their son to the gentleman who had performed the internal urethrotomy and to a number of other special workers, but none of them had offered any suggestions. In fact, as far as I am aware, no one had ever heretofore attempted to radically correct such a deformity. At last, yielding to the solicitations of the parents, I promised to make the attempt, provided they agreed to hold me blameless in case of failure not only to cure the defect, but also should the operation leave the patient in a condition more unsatisfactory than before.

The operative idea which entered my mind was to cut through the urethra and the surrounding unyielding tissues, and then to cause a separation of the ends sufficiently to make up for the urethral shortening, the space between the ends being left to fill in by granulation, as in extensive urethral resections. I was afraid to resect the penile urethra anterior to the scrotum lest a fistula should persist. The perineum was accordingly laid open from just above the rectum up onto the uplifted scrotum. The urethra was then cut across very obliquely in the bulbous region. The penile end, in order to facilitate its retraction, was dissected free from the surrounding tissues for about three-quarters of an inch, after which the penis was pulled up and bent back over the

pubes. In that position of the penis a maximum amount of separation of the cut urethral ends occurred. Then, while maintaining the penis in that position, the penile end of the urethral roof was carefully stitched with fine catgut to its surrounding tissues, while a longitudinal half-inch cut was made along its floor. The urethral roof of the posterior end required no such stitching, as it had not been dissected free from its surrounding tissues. This done, a perineal vesical drainage-tube was inserted, after which my usual urethral tube was adjusted and the perineal incision carefully closed by suture. The penis was left bent back over the pubes and secured in that position by transverse strips of plaster. The wound healed well, and the operation was a distinct success.

The young man, now nearly two years afterwards, has a good free stream on urination and a penis which is nearly straight during erection. The sexual act can be accomplished without any difficulty, and his bar to matrimony is consequently removed.